IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 15, 2006

FILE COPY

Ferren Weeks, Administrator
Yellowstone Group Homes #1, #2, & #5
560 West Synnyside Lane
Idaho Falls, ID 83401

RE: Provider Number 13G063, 13G064, and 13G067

Dear Mr. Weeks:

This is to advise you of the findings of the State Licensure and Medicare/Medicaid fire safety survey of the following ICFs/MR conducted on June 7, 2006.

Yellowstone Group Home #1 located at 3335 Springfield, Idaho Falls
Yellowstone Group Home #2 located at 3245 Sunnybrook Lane, Idaho Falls
Yellowstone Group Home #5 located at 4541 East Burke Drive, Ammon

Enclosed is a Statement of Deficiencies/Plan of Correction, form CMS-2567, and the State fire safety Statement of Deficiencies and Plan of Correction form listing fire and life safety deficiencies. In the space provided on the right side of each form, answer each deficiency and provide a date each will be corrected. Include in your plan of correction necessary corrective measures taken, provisions implemented to prevent re-occurrence, and department head/person responsible to monitor/assure that the deficiencies do not re-occur.

After you have answered and dated each deficiency, please sign and date the pages in the spaces provided. Retain one copy of each page for your files and return the originals to this office by **Tuesday, June 27, 2006.**

Thank you for the courtesies extended to me by you and your staff during my visit. Please call or write this office with any questions.

Sincerely,

Caswell Merritt nm

CASWELL MERRITT, Health Facility Surveyor
Facility Fire Safety & Construction

CM/nm
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G067	A. BUILDING 01 - ENTIRE STRUCTURE B. WING _____	06/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #5 (BURKE)	4541 E BURKE DR AMMON, ID 83406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility is a single story, type V (000) construction. It is fully sprinklered (except garage and attic areas) with Quick Response sprinkler heads. It is a rural location on a large lot. It has a complete fire alarm/smoke detection system. This home was built/completed on April 10, 1998. Currently it is licensed for 6 ICF/MR beds. The fire/life survey was conducted by Caswell Merritt and Christopher Laumann, Facility Fire Safety & Construction Section, Bureau of Facility Standards, Idaho Department of Health and Welfare. The following deficiencies are based on provisions set forth in the LIFE SAFETY CODE-2000 Edition for Residential Board & Care Chapter 33, Impractical Evacuation Capabilities.	K 000		
K0018	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.	K0018	Please refer to the attached PoC for all deficiencies listed. RECEIVED JUN 26 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerome J. Weiss	Regional Administrator	6/20/06

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0018	Continued From page 1 This Standard is not met as evidenced by: Based on observation and review of monthly preventative maintenance records, one of three sleeping room doors was not smoke resistant. Findings Includes: During Facility tour on June 6, 2006 at 11:25 AM, the second bedroom door on the left when closed would not latch. This was not noted on the most recent monthly maintenance records.	K0018		
K0150	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1 This Standard is not met as evidenced by: Based on interview and observation of privacy curtains while on tour of the facility, a privacy curtain was observed not to be labeled as fire resistant or flame retardant. Findings include: During the tour of the facility at 11:15 AM, one of three bedrooms with a privacy curtain in each bedroom was observed to have a privacy curtain that was not labeled as flame retardant or rendered flame resistant. Maintenance staff stated that new privacy curtains that were flame resistant were installed , however one bedroom was missed.	K0150		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K0150	Continued From page 2 Repeat deficiency from June 1, 2005.	K0150		

Bureau of Facility Standards

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MM001	16.03.11001 Title and Scope These rules contain the official legal requirements and licensing standards for the administration of intermediate care facilities for the treatment of mental retardation (ICF/MR). These rules are to be cited as Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)." This Rule is not met as evidenced by: * The following State Licensure deficiency was cited during the annual fire safety survey of the above facility.	MM001		
MM346	16.03.11.110.06(g) In-House Check The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems. This Rule is not met as evidenced by: Based on surveyor observation, the TV located in the living room was plugged into an extension cord that was plugged into the wall electric receptacle. Findings Include: During the tour of the facility at 11:30 AM on June 6, 2006 the TV located in the living room was observed to be connected to electrical service with an extension cord. This was verified with the maintenance staff.	MM346		

RECEIVED
JUN 26 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica J Weeks	Regional Administrator	6/21/06

June 21, 2006

Caswell Merritt, Health Facility Surveyor
P.O. Box 83720
Boise, ID 83720–0036

Dear Mr. Merritt:

Here are the plans of correction for the recent surveys of Yellowstone Group Homes #1, #2, and #5. I hope that the corrections we are making are satisfactory. If not, please contact me and we can discuss it further.

I appreciated your visit as always and am saddened by the fact that you won't be back to survey us. I've enjoyed your stories over the years as they were quite interesting. I wish you the very best for what life brings you now.

Sincerely

Ferren

6/21/06

Fire/life safety plan of correction for Yellowstone Group Home #5(Burke).

K0018 – This room is occupied by a client that has a history of slamming his door, which requires ongoing repair. The staff will be in-serviced on the importance of addressing this on all fire drills to assure that all doors are operating properly and those repairs, especially this particular door, are reported and completed. The home administrator will be responsible for doing this staff training. The home administrator will also be responsible for reviewing all reports to assure that it is being done. Revisions will be made to the Burke fire drill to specifically list this door and knob as it requires additional attention. This will be completed by 6/30/06.

K0150 - The privacy curtain in question was indeed one of our older ones that didn't contain a label. New privacy curtains had been purchased and the old ones were replaced throughout our homes. This one was inadvertently missed. The old one was discarded and was replaced immediately. The facility does have a supply of additional new curtains for future use. The home administrator has completed this by 6/21/06

MM346 - The staff will be in-serviced by the Burke home administrator regarding the need to use power strips rather than a simple extension cord. The cord has been replaced and the staff will be in-serviced by 6/30/06. To provide adequate check procedures in the future, the home environmental assessment form used at the home will have this specific concern listed so that needed corrections can be identified and completed. The regional administrator will make the changes to this form by 6/30/06.

Jerren J. Weeks
Regional Administrator.